STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF CHILD SUPPORT (DCS)

WASHINGTON STATE ADDENDUM TO BOX 2 OF PLAN ADMINISTRATOR RESPONSE

TO: DIVISION OF CHILD SUPPORT
PO BOX 11520
TACOMA WA 98411-5520

RE:

SSN:

IV-D CASE NUMBER:

FROM: _____ (Please enter Plan Administrator name)

The children listed in Part B, Medical Support Notice to Plan Administrator are enrolled in the following plan(s). Send all claims to (names and addresses):

HEALTH INSURANCE PLAN	
COMPANY NAME AND ADDRESS	POLICY NUMBER:
	GROUP NUMBER:
	TELEPHONE NUMBER:

DENTAL INSURANCE PLAN	
COMPANY NAME AND ADDRESS	POLICY NUMBER:
	GROUP NUMBER:
	TELEPHONE NUMBER:

PRESCRIPTION DRUG INSURANCE PLAN	
COMPANY NAME AND ADDRESS	POLICY NUMBER:
	GROUP NUMBER:
	TELEPHONE NUMBER:

VISION INSURANCE PLAN	
COMPANY NAME AND ADDRESS	POLICY NUMBER:
	GROUP NUMBER:
	TELEPHONE NUMBER: